THE EFFECTIVENESS OF COMMUNITY ENGAGEMENT AND PARTICIPATION APPROACHES IN LOW AND MIDDLE INCOME COUNTRIES: AN EVIDENCE SUMMARY WITH PARTICULAR REFERENCE TO THE COUNTRIES OF SOUTH ASIA

Contextualisation of the Evidence Summary to South Asia and Nepal, December 2017

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Picture

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CONTENTS

EXECUTIVE SUMMARY

Community engagement and participation approaches in South Asia and Nepal could be successful in the area of maternal and child health. Policy options should focus on appropriate incentives for volunteers; and local geographical, social, and cultural norms should be taken into account when engaging government, NGOs and the public.

ABOUT THIS SUMMARY

- The aim of the contextualisation process is to conduct a contextual analysis of the evidence summary comprising 31 systematic reviews (Pilkington et al., 2017).
- This contextualisation document is designed to present findings of the evidence summary in the context of South Asia and Nepal.
- This document will assist policy-makers and researchers in assessing the evidence in this field in the context of regional setting and conditions. This document presents current evidence regarding effectiveness of interventions in particular contexts which should be interpreted in the form of potential policy implications but not policy recommendations.

APPROACH

The contextualisation process was iterative; findings from 31 systematic reviews were discussed with an Advisory Group who drew on their knowledge, experience and understanding of South Asia and Nepal to consider the applicability and relevance of the review findings to those populations. The Advisory Group were asked to consider a set of questions on the applicability of the evidence and the practicalities of implementing the findings of the evidence review.

SUMMARY OF CONTEXTUALISATION ANALYSIS

Community engagement and participation approaches have been adopted in many LMICs, including South Asia and Nepal, as a response to critical shortages of human resources for health. Community engagement and participation activities in Nepal and other South Asian countries have included provision of health education (for example, through educational materials, educational meetings and educational outreach visits), provision of incentives using community structures, mobilisation of human resources, involvement of local opinion leaders and spreading messages through mass media. Community health worker programmes have been mobilised in most of the low-resource settings of South Asia, in rural as well as urban areas. Nepal is well known for its public health programmes and as one of the poorest countries in South Asia, uses a large number of community health workers. However, unlike other programmes in South Asia, community health workers in Nepal do not get paid.

The success of community engagement and participation approaches is linked with sustainability; our contextualisation draws out some key factors for consideration in the delivery of successful and sustainable community engagement and participation in South Asia, and with particular reference to Nepal where feasible.

The evidence identified which is most relevant to communities in South Asia and Nepal relates to maternal and child health. To ensure the findings are put into practice, NGOs and their local partners, community members and their representatives are required to take action and enable policy options to be optimised. The following key messages outline the potential policy implications and options that could lead to successful and sustainable community engagement and participation approaches to improving health outcomes. Note that any action taken should consider the socio-cultural, political and religious context of the particular setting.

KEY MESSAGES FOR POLICY-MAKERS AND RESEARCHERS

The following key messages for policy-makers and researchers are drawn from the evidence summary comprising 31 systematic reviews (Pilkington et al., 2017). The evidence included in the evidence summary was derived from LMICs; many of the included systematic reviews included primary studies conducted in South Asia (for example India, Pakistan, Bangladesh), and a significant number of systematic reviews included primary studies conducted in Nepal. However, as evidence was synthesised at the systematic review-level, the contextual detail required to strongly distinguish between regional and country specific actions was lacking. Furthermore, tailoring of these key messages may be required to support their delivery.

- Design locally viable economic or non-monetary incentive systems in partnership with communities and ensure they are culturally appropriate, consistent and fair. It is important to consider that for community health workers that do not get paid (as is the case in Nepal), incentives could support their daily livelihood.
- Support the strengthening of direct involvement by the public, citizens or users to improve the delivery of health services in South Asian countries. Also; promote involvement of NGOs, leaders and local respectable and acceptable people from the community.
- Actions should be as specific as possible, and has to be devised on a case-by-case basis covering policy and planning; service management and delivery; and research priorities. Policy-makers and program managers should be flexible to adapt to changing environments and restraints throughout the development, implementation and ongoing management of programs involving community participation approaches and should regulate health programmes, taking the precise context of the situation in which programmes are to be implemented.
- Assist communities to identify and prioritize their own health concerns. Ensure they are actively involved in all stages of programme planning and implementation (i.e. a ‘bottom up’ approach).

- Use locally appropriate volunteer selection and recruitment processes. Ensure inclusive selection that reflects the characteristics of the beneficiary community. Consider how communities can be involved in selection processes.
- Ensure financial and human resources are available to build managerial, organisational and technical capacity at the community level. Appreciate that active community engagement and participation can be challenging and requires resources.
- Investigate social and cultural norms, knowledge and perceptions, and use the findings to inform culturally appropriate behaviour change communication as the foundation of community engagement and participation. Consider how to address varying levels of health education needs.

STRENGTHS AND LIMITATIONS

The strengths of this contextualisation process include:

- It is built on a rapid evidence assessment which identified a number of systematic reviews which included primary studies located in South Asia and Nepal; a high proportion of the evidence relates to maternal and child health, which is a major focus of community health worker activity in the region.
- It uses input from Advisory Group members with expertise and knowledge relating to South Asia and particularly Nepal.

The findings of this summary should be interpreted with caution due to the inherent limitations of the evidence and the contextualisation process. The limitations of the contextualisation process include:

- Information collected at the systematic review level is not detailed enough to allow for an understanding of the mechanisms by which community engagement and participation approaches work, and whether those approaches can be translated to a South Asian or Nepalese setting.
- A lack of information such as geographical locations, population details and types of community engagement and participation means that translation and contextualisation of evidence is problematic.
- Due to characteristic differences/heterogeneity of study designs, populations, study sites and interventions the overall findings of the Rapid Evidence Assessment are limited.
- There are significant evidence gaps for areas other than maternal and child health, and the prevention, control, and treatment of communicable diseases such as malaria, tuberculosis and HIV.

BACKGROUND

Community engagement and participation can be considered the 'direct or indirect process of involving communities in decision-making and/or in the planning, design, governance, and delivery of services using methods of consultation, collaboration, and/or community control' (O'Mara-Eves et al., 2013). The increasing level of engagement that participants have in the process is often represented by a continuum or a 'ladder' ranging from information sharing to full responsibility and ownership (Farnsworth et al., 2014, Rifkin, 2014, Rosato et al., 2008). For the purposes of the rapid evidence assessment the core review team drew on the definition of community engagement or participation approaches as those that "decentralise decision-making by including participation of communities in project design, development, contractor selection, project management and supervision".

Community engagement is a complex social process that is situation specific. What works in one community should not be expected to work in the same way or with the same effect elsewhere (McCoy et al., 2012). Therefore, it is important to understand the process by which interventions were successful and the context in which these practices took place (McCoy et al., 2012). The following conceptual framework was used by the core review team throughout the process of conducting the rapid evidence assessment and contextualising the evidence to South Asia and Nepal to better understand the complexities of community engagement and participation approaches (Pilkington et al., 2017).

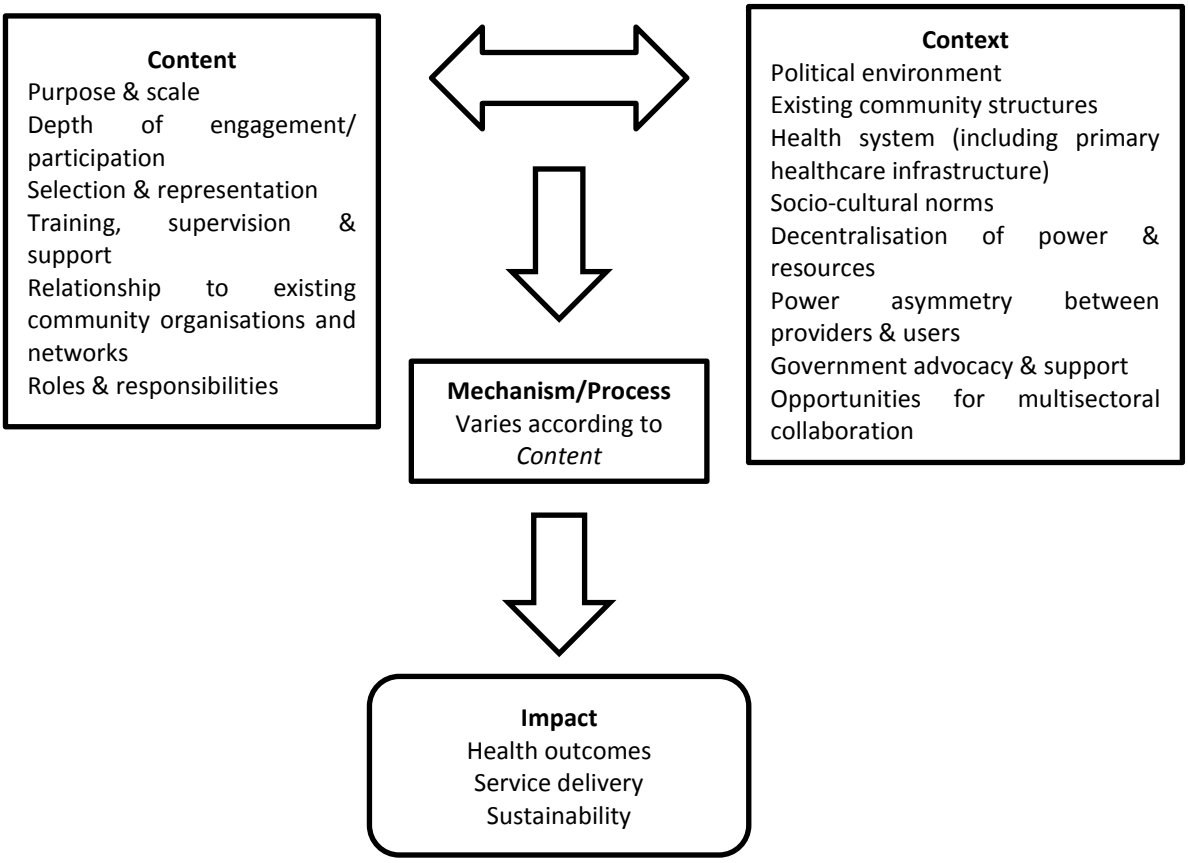

Figure 1. Pathway from community engagement/participation to impact

COMMUNITY ENGAGEMENT AND PARTICIPATION APPROACHES IN SOUTH ASIA, AND PARTICULARLY NEPAL

Due to critical shortages of human resources for health, many LMICs, including those within South Asia, have adopted community engagement and participation as an approach to enhance access to basic healthcare services for poor populations (Pallas et al., 2013, World Health Organization, 2011). Different approaches to community engagement and participation include for example: providing health education through materials, meetings and outreach visits, provision of incentives using community structures, mobilising human resources, involvement of local opinion leaders and spreading messages through mass media (Adhikari et al., 2016, Atkinson et al., 2011, Heintze et al., 2007). Community health worker programmes have become the most prominent model of community engagement and participation, and have been mobilised in most of the low-resource settings of South Asia, in rural as well as urban areas (Hossain et al., 2004). Community health workers particularly play a key role in improving the reach of health systems to under-served populations (McCollum et al., 2016). Community health workers have been deployed as a means for achieving a range of disease prevention and health system strengthening objectives in the countries of South Asia (Pallas et al., 2013). Common community engagement and participation activities include those targeting maternal and child health, newborn care, infectious diseases and health promotion activities (including awareness and prevention of tuberculosis, HIV and malaria). Usually, community health workers are involved in the region to educate community members about health risks, promoting healthy behaviours, or link community members with providers at formal health care facilities.

Nepal is well known for its public health programmes and wide successes in campaign based interventions as a result of active involvement of volunteers and organisations based in the community. As one of the poorest countries in South Asia, Nepal uses a large number of community health workers known as female community health volunteers (Panday et al., 2017). While trained and mobilised by non-governmental organisations (NGOs) in some countries, community health workers in Nepal (although community health workers are often mobilised by local NGOs) are part of the national public healthcare system. Besides female community health volunteers there are two other community-level healthcare workers in Nepal, maternal and child health workers and village health workers. However, female community health volunteers are the main group providing the main basic maternal and child health care including family planning services in rural communities. The female community health volunteers facilitate mothers' group meetings in every rural village unit, where local women gather and discuss health related issues such as maternal, child and newborn health, and family planning. The groups may also discuss strategies to reduce infectious diseases such as pneumonia and diarrhoea. However, true community engagement via such groups has been limited (Kc et al., 2011).

Unlike other community health worker programmes in South Asia, community health workers in Nepal do not get paid. Nepal is unique to employ this cadre; in India, for example, Accredited Social Health Activists (ASHAs) are the key cadre in the community health worker programme, and although not formally salaried they are incentivised to deliver care (Khan et al., 2010). Similarly, in Bangladesh, volunteer 'Swasthya Sevika' are mobilised to provide basic healthcare to its communities. These volunteers make some money from selling commodities (Alam et al., 2012).

Community engagement and participation approaches in South Asia have not followed one particular model. Models have been community-, NGO- or third sector-, and government-led, or mixed, with planning and implementation organised around both horizontal ('bottom-up') and vertical ('top-down') approaches (Atkinson et al., 2011). Community engagement and participation activities in Nepal and other South Asian countries have included provision of health education (for example, through educational materials, educational meetings and educational outreach visits), provision of incentives using community structures, mobilisation of human resources, involvement of local opinion leaders and spreading messages through mass media (Adhikari et al., 2016, Atkinson et al., 2011, Heintze et al., 2007). In many health systems across the countries of South Asia, health committees, councils or boards mediate between communities and health services to provide accountability to citizens (George et al., 2015, McCoy et al., 2012). In Bangladesh, for example, health committees are an important part of the healthcare system and local committee representatives have a strong role in ensuring effective management of healthcare delivery and the quality of care.

METHODS OF CONTEXTUALISATION

This document presents a contextual analysis of the evidence summary (*The effectiveness of community engagement and participation approaches in low and middle income countries: a review of systematic reviews with particular reference to the countries of South Asia*). The evidence summary was conducted using systematic review methods to identify, analyse and summarise the findings of existing systematic reviews that have examined the effectiveness of community engagement/participation approaches in improving health, service delivery and sustainability outcomes. The main research question guiding the review process was: *How effective are community engagement/participation approaches for delivering better health outcomes, improving service delivery and sustaining benefits?*

METHODS OF COLLABORATION

Using a committee approach, the core review team and Advisory Group members considered the evidence statements developed from the evidence summary, based on the Advisory Groups' knowledge, experience and understanding of the target populations. The Advisory Group includes a number of organisations and individuals from India, Bangladesh, Nepal and UK with a range of expertise in systematic reviewing and sector specific research in South Asia.

An initial meeting was set up using Skype, to allow for discussion and to further the contextualisation process. The process was iterative. A series of online meetings, emails, group and one-to-one Skype conversations were scheduled to enable all Advisory Group members to participate.

THE ROLE OF THE ADVISORY GROUP

Based on the applicability and relevance of the evidence to the context of South Asia, and particularly Nepal, the Advisory Group was asked to consider:

i. Whether or not it will be possible to put the findings of the rapid evidence assessment into practice.

ii. The degree of change in practice required and support needed to put the findings into practice (if at all); including aspects such as staff training needs, policy levers and resources required in terms of people and finance.

iii. Any negative effects that may arise from putting the findings into practice and whether these are offset by anticipated benefits.

iv. The potential for impact on individual and population health from putting the findings into practice.

v. Any uncertainty and gaps in putting the findings into practice and relating to important policy concerns.

Questions were framed under the themes of:

a. Whose health will benefit?
b. Who should take action?
c. What action should be taken?

SUMMARY OF THE FINDINGS OF THE EVIDENCE SUMMARY

The evidence summary identified 31 systematic reviews which examined the effectiveness of community engagement or participation approaches in improving health, service delivery and sustainability outcomes in LMICs. Not all of the systematic reviews identified in the evidence summary included primary studies that were conducted in South Asia, much of the evidence came from South America, the Caribbean, Africa, and East Asia. Many of the included systematic reviews were not specific in the reporting of primary studies, so there are gaps in the evidence base. However, where reported explicitly, many of the included systematic reviews included studies in South Asia (India, Pakistan, Bangladesh), and a significant number of systematic reviews included primary studies located in Nepal. These were primarily related to maternal and child health.

Results from the evidence summary suggest that for maternal and child health there may be reductions in maternal mortality, neonatal mortality, early neonatal mortality, perinatal mortality, and stillbirths, and that there could be an association with improved care seeking

for childhood illnesses. In terms of communicable diseases, findings suggest that there could be an increase in condom use among sex workers, but there is insufficient evidence to draw conclusions relating to HIV/STI prevalence. Results also suggest that there may be a small increase in the effectiveness of tuberculosis treatment linked to the involvement of community health workers.

CONTEXTUALISATION RESULTS

This section focusses on the policy implications that can be drawn from the contextualisation process, based on finding of 31 systematic reviews. The evidence identified which is most relevant and applicable to South Asia and Nepal concerns maternal and child health, and in particular the use of community/lay health workers to improve health outcomes. Evidence relating to tuberculosis or HIV is considered less relevant to the South Asian and particularly Nepalese populations.

POLICY IMPLICATIONS FOR SOUTH ASIA AND NEPAL

The policy implications are presented in terms of whose health will benefit, who should take action, and what action should be taken, as outlined in the methods of collaboration.

WHOSE HEALTH WILL BENEFIT?

Community engagement and participation approaches in South Asia and Nepal should focus on the following groups:

- Communities and groups with maternal and child health needs
- Communities with limited access to health services

However, there may be other groups whose health would benefit from community engagement and participation approaches. Please see the section on evidence gaps.

WHO SHOULD TAKE ACTION?

Action should be taken by:

- Group A: Those in Government involved in the planning (including co-ordination), design, funding and evaluation of national, regional and local policy initiatives
- Group B: NGOs and their local partners involved in the planning, design, delivery and management of community engagement and participation approaches
- Group C: Community members and their representatives

Group A: Those in government should play a significant role in the co-ordination of community participation interventions.

Group B: The role that NGOs and community-based organisations play in the delivery and management of community engagement and participation approaches may be equally as important in the context of South Asia and Nepal.

NGOs and local partners are key in areas where government managed services do not reach, remote areas, for example. The governments of South Asian countries have limited resources, and especially lack skilled human resources for health. Therefore, effective collaboration and coordination with NGOs might be helpful to extend healthcare for hard-to-reach populations.

The role of public-private partnerships in delivering sustainable community engagement and participation efforts warrants attention. Where there are deficiencies in the public health system, partnerships between the public and private sector have been important in the delivery of quality, affordable healthcare.

Group C: Often the acceptability of the community engagement and participation approach is a key issue, communities should be empowered to take ownership and responsibility for the project and its success.

WHAT ACTION SHOULD BE TAKEN?

Community engagement and participation approaches continue to be viewed as important, particularly in LMICs. The general trend in the evidence identified suggests that community engagement and participation approaches have played a role in successful intervention delivery across health system domains and areas of health. However, the extent to which community ownership and empowerment is achieved greatly impacts on the sustainability of these approaches and our evidence draws out some key factors for consideration in the delivery of successful community engagement and participation.

Findings from systematic reviews examining the sustainability of community participation approaches identified several themes which are key to successful outcomes: social and cultural norms and perceptions, incentives, gender roles and power relationships, community characteristics, consideration of local priorities, the process by which communities are engaged to participate, government advocacy and support, health system integration, political environment, and locally embedded development agencies.

Any action taken should consider the socio-cultural, political and religious context of the particular setting. Community engagement and participation approaches are situation specific. What works in one community might not work with the same effect, in the same way elsewhere. The principles outlined in the table below however aim to provide support to those looking to put the findings of the evidence summary into practice.

Policy area	Policy implication(s)
Volunteer related	
Incentives	• Volunteers are often poor women who are already overburdened. Research is necessary to find a suitable model in order for volunteers to maintain and sustain community engagement activities. • Design locally viable economic or non-monetary incentive systems in partnership with communities and ensure they are culturally appropriate, consistent and fair. It is important to consider that community health workers that do not get paid (as is the case in **Nepal**) and require incentives to support their daily livelihood. • Good performance of community workers in Asian countries is associated with intervention designs involving a mix of financial and non-financial enticements like provision of incentives, regular supervision, repeated trainings, and strong coordination and communication between community workers and health professionals.
Training and performance	• Certain potential facilitating factors of community health workers such as higher education, experience with health conditions to be dealt with, and availability of training has also been shown to improve the health outcomes in South Asia. • Additional factors associated to enhance performance of the community workers in this region are provision of incentives, longer service delivery times, and good co-ordination with other health staff.
Infrastructure	
Government/NGO involvement	• To augment support to community engagements and participation approaches in South Asian countries; policies are advocated to limit competition from other service providers like unlicensed pharmacies. Also; funding mechanisms backed by multiple parties (e.g., community, local government, central government) should be developed to lessen dependence on a single funding source. • Secure government advocacy and support for community engagement and participation. • Embedded NGOs should be engaged to contribute resources to support community engagement and participation. In Nepal, the presence of several NGOs and third sector involvement in the mobilisation of community health workers means that coordination is necessary for effective community engagement and participation
Public involvement	• To improve the delivery of health services in South Asian countries, strengthening direct involvement of the public, citizens or users should be supported. Also; involvement of NGOs, leaders and local respectable and acceptable people from the community should be promoted. • Assist communities to identify and prioritize their own health concerns. Ensure they are actively involved in all stages of programme planning and implementation (i.e. a 'bottom up' approach).

	• Use locally appropriate volunteer selection and recruitment processes. Ensure inclusive selection that reflects the characteristics of the beneficiary community. Consider how communities can be involved in selection processes.
Sustainability	• Policy-makers, practitioners, and researchers seeking to scale-up and sustain programmes through community engagements and participation approaches should foster programmes that are acceptable to the particular communities served and should amalgamate the programme with the larger political, economic, and health system environment. There is a need to develop criteria for identifying cases of scale-up, sustainability, and success of health programmes through community engagements and participation in Nepal and other South Asian countries. • Support and strengthen direct involvement of the public, citizens or users should be. Actions should be as specific as possible, and has to be devised on a case-by-case basis covering policy and planning; service management and delivery; and research priorities. Policy-makers and programme managers should be flexible to adapt to changing environments and restraints throughout the development, implementation and ongoing management of programs involving community participation approaches and should regulate health programmes, taking the precise context of the situation in which programmes are to be implemented. • Ensure financial and human resources are available to build managerial, organisational and technical capacity at the community level. Implementation of active community engagement and participation can be challenging and requires resources. • Investigate social and cultural norms, knowledge and perceptions, and use the findings to inform culturally appropriate behaviour change communication as the foundation of community engagement and participation. Consider how to address varying levels of health education needs. • Investigate social and cultural norms, knowledge and perceptions, and use the findings to inform culturally appropriate behaviour change communication as the foundation of community engagement and participation. Consider how to address varying levels of health education needs.
Barriers	• Give specific consideration to the local factors that may hinder the engagement and participation of women and those from marginalised groups.

EVIDENCE GAPS

Thirty-one systematic reviews were identified for inclusion in the evidence summary. However, gaps in the evidence identified through the contextualisation process include:

- A lack of evidence on the role of community engagement and participation approaches in programmes aiming to
    - Control or eliminate communicable diseases
    - Prevent or treat non-communicable diseases
- Effective approaches to scaling-up and sustaining health programmes involving community participation in South Asia.
- Concepts, motivations and social practices supporting community engagement and participation in South Asian countries.

The findings of the evidence summary suggest that community engagement and participation approaches are effective for populations such as pregnant women and lactating mothers (age 15-49 years) and children (under 5 years). However, the Advisory Group members felt that community engagement and participation approaches could potentially be effective for people of all ages. It was felt, for example, that adolescents could stand to benefit from community engagement and participation approaches targeting areas such as reproductive health. Geriatric populations were another group who it was felt may benefit; with community engagement and participation approaches suggested as having the potential to help address the challenges of an expanding elderly population in South Asia.

Further gaps were identified within the following domains: immunisation; mental health services; and improving nutritional status.

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ABBREVIATIONS

HIC	High income country
HIV	Human immunodeficiency virus
LMIC	Low and middle income countries
NGO	Non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
SARH	South Asia Research Hub
STI	Sexually transmitted infection
WHO	World Health Organization